ADVANCED PODIATRY SPECIALISTS

Board Certified, American Board of Podiatric Medicine

Carl M. Salvati, DPM
812 N.E. 25th Ave., Ste A
Ocala, Florida 34470
Ph: (352) 351-4444 Fax: (352)351-4920

Armando Gonzalez, DPM
3300 SW 33rd Rd
Ocala, Florida 34474
Ph: (352)873-3332 Fax: (352)873-0722

DEMOGRAPHICS (PRINT)

Date: _____
Name: _____
Birthdate: _____ Age: _____
Sex: ☐ Male ☐ Female
☐ Married ☐ Single ☐ Divorced ☐ Widow
SS#: _____

Home Phone: (_____) _____-_____
Cell Phone: (_____)_____-_____
Preferred Contact Method: ☐ Home ☐ Cell
Text Notification ☐ Yes ☐ NO Email Notification☐ Yes☐ No
Address_____
City_____
State_____ Zip_____
Email: _____
Please List Who Referred You: _____

PATIENTS UNDER 18 YEARS OLD ONLY

Guardians Name: _____

Relation: _____

Phone: (_____) _____-_____

EMERGENCY CONTACT INFORMATION

Name: _____
Contact Number: _____
Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____
Policy Number: _____
Secondary Insurance: _____
Policy Number: _____

PHARMACY

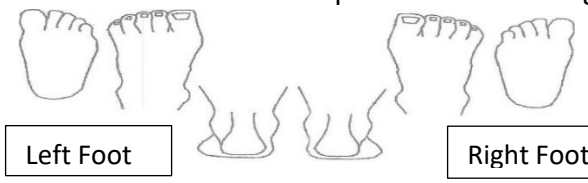
Preferred Pharmacy and Location: _____

CHIEF COMPLAINT

What is the problem/condition you are having?

_____

Please indicate the source of problem on the diagrams:



No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Current Pain Level: _____ Worst Pain Level: ____

Is this complaint due to an injury ☐ Yes ☐ No

Is this injury work related ☐ Yes ☐ No

Please indicate which problem(s) you are experiencing:	
Numbness/Burning/Tingling in Foot	☐ Yes ☐ No
Cramps and Spasms	☐ Yes ☐ No
Swelling of Leg(s)	☐ Yes ☐ No
Leg Pain	☐ Yes ☐ No
Ankle Pain	☐ Yes ☐ No
Heel Pain	☐ Yes ☐ No
Foot Pain	☐ Yes ☐ No
Calluses	☐ Yes ☐ No
Plantar Warts/Skin Lesions	☐ Yes ☐ No
Wound/Ulcer	☐ Yes ☐ No
Deformed/Fungal Toenails	☐ Yes ☐ No
Ingrown Toenails	☐ Yes ☐ No
Weakness in Leg/Ankle/feet	☐ Yes ☐ No
Balance Problems	☐ Yes ☐ No

PAST MEDICAL HISTORY

☐ Diabetes
☐ Arthritis
☐ Osteomyelitis
☐ Fibromyalgia
☐ History of Pulmonary Embolism
☐ Heart Disease
☐ High Blood Pressure
☐ GERD/Gastric Ulcer
☐ Skin Cancer
☐ Liver Disease
☐ Neuropathy
☐ RSD / CRPS
☐ Peripheral Vascular Disease
☐ Kidney Disease
☐ Venous Insufficiency
☐ Stent Placement in Lower Extremity
☐ Implant: Pacemaker or Defibrillator
☐ Other: _____

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PAST SURGICAL HISTORY (PRINT)

Please list any past surgeries:

_____
_____
_____

Did you tolerate anesthesia well? ☐Yes ☐No

FAMILY/SOCIAL HISTORY

Mother: ☐ Deceased ☐ Living
Medical History: _____

Father: ☐ Deceased ☐ Living
Medical History: _____

Do you use tobacco? ☐ Yes ☐ No
If **YES**:
Type: ☐ Pipe ☐ Cigar ☐ Cigarettes ☐ Chew
How Often: _____
If you are a FORMER TOBACCO USER:
How long ago did you quit? _____

Do you use Alcohol? ☐ Yes ☐ No
If **YES**:
How Often: _____

Do you have a history of Diabetes? ☐ Yes ☐ No
IF YES: ☐ Type I ☐ Type II ☐ Other: _____
Name of Monitoring Physician: _____
Date Last Seen by this Physician: _____

Name of Primary Care Physician: _____
Last Date Seen By PCP: _____

REVIEW OF SYSTEMS

Please ***circle*** any other significant medical history that you feel would be pertinent to your treatment at our facility:

General: Weight Gain-Loss; Change in strength or exercise tolerance; Fever; Chills; Fatigue; Lethargic; HIV/AIDS

HEENT: Headaches/Migraines; Dizziness; Traumatic Brain injury; Blurred Vision; Change in Vision; Hearing Loss; Ringing of Ears; Nose Bleeding; Trouble Breathing; Running Nose; Dental difficulties; Bleeding gums; Use of dentures/Implants; Neck Stiffness; Noted Masses on Neck; Frequent Sore Throat; Thyroid Problem; Trouble Swallowing

Lungs: Wheezing; Coughing of Blood; Chronic Cough; Shortness of Breath; Infection of Lungs

Heart: Chest Pain; Palpitations; Heart Valve Problems; Fainting; Infections of Heart

Abdomen: Loss of Appetite; Diarrhea; Nausea/Vomiting; Bloody Stool

GU: Frequent Urination; Urinary Tract Infection; Change in nature of urine.

Gyn: Change in menses; Pain with Menses; Vaginal discharge; Pelvic pain; Menopausal

Dermatologic: Callus; Wound; Rash/Itching; Change in Mole; Deformed Toenails; Infection of Skin

Musculoskeletal: Pain in muscles or joints; limitation of Joint or Joint Stiffness; Foot/Ankle Swelling; Infection of Bone

Neurologic: Weakness; Tremor; Seizures; Memory Loss; Trouble with Balance; Numbness or Loss of Sensation

Psychiatric: History of Depression; History of Anxiety; Trouble Sleeping; Thoughts of Suicide

Other: _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

X_____ _____
Signature Date

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Name: _____ **Date: _____**

Date of Birth: _____

Medication List/Allergies Passport

Please fill this form out completely and bring it with you when you visit any Medical Professional/Pharmacy. Include all medications (prescribed and over the counter) and vitamins that you are currently taking.

Medications (PRINT)

Name	Dose	How often	Prescribing Doctor
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Drug Allergies (PRINT) **Yes ☐** **No ☐**

Allergen (Drugs)	**Severity** (Mild, Moderate, Severe)	**Reaction** (Anaphylaxis, Rash)		**Onset** (Childhood, Adult, Unknown)
1.				
2.				
3.				
4.				
5.				

HIPPA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have read Carl M. Salvati, D.P.M. HIPPA Notice of Privacy Practice

LIFETIME AUTHORIZATION

INSURANCE ASSIGMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION- I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as insurance company or governmental agency, e.g.- Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determine a claim for payment for such treatment and/or diagnosis.

II. PHYSICAIN INSURANCE ASSIGNMENT- I, the below named patient, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID- Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under TitleXVII/XIX of the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. The assignment will remain in effect until revoked by me in writing.

V. CONSENT FOR TREATMENT- I, the below named patient, hereby give my consent for treatment to all physicians associated with Armando Gonzalez, D.P.M or Carl M. Salvati, D.P.M.

VI. CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do authorize Armando Gonzalez D.P.M or Carl M. Salvati, D.P.M. to discuss my medical condition with, or release my medical records to the below named person(s):

Name: _____ Relationship _____

Name: _____ Relationship _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third-party payor within reasonable period of time not to exceed 60 days. If the amount is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Patient Signature: _____ Date_____

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Advanced Podiatry Specialists, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **WILL NOT** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Advanced Podiatry Specialists to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Print Name

_____

Signature of Patient

_____

Date

Medical Records Request Form

Carl M. Salvati, D.P.M.
812 NE 25th Ave., Suite A
Ocala, FL 34470

Date: _____

Name (Print): _____
D.O.B.: _____

I hereby give authorization to release my medical records from:

Name of Medical Facility/Physician: _____
Phone: _____ Fax: _____

- ☐ **Labs**
- ☐ **Last office notes**
- ☐ **Medication List**
- ☐ **X-rays**
- ☐ **MRI's**
- ☐ **Operative Report**
- ☐ **All Medical Records**
- ☐ **Other: _____**

Fax To:

Fax (352) 351-4920

Patient Signature: _____ Date: _____

Practice Financial Policy

Thank you for choosing Advanced Podiatry Specialists as your health care provider. We are committed to building a successful physician-patient relationship, and the success of your medical treatment and care. Your understanding of our Practice Financial Policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions. If you need further information or assistance about any of these policies, please ask to speak with our practice Manager.

When are payments due?

All copayments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made with our billing coordinator.

Which plans do you contract with?

Advanced Podiatry Specialists accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan. If we are not a provider under your insurance plan, you will be responsible for payment in full at the time of service.

As a courtesy, however, we will file your initial insurance claim, and if not paid within 45 days, you will be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you.

Do you charge a penalty for returned payments?

Any charges incurred Dy the practice collecting balances owed to us during the collection process may be charged to the patient. Returned checks, credit card chargebacks, or returned payments will attract a minimum 535 penalty in addition to the balance owed. Accounts with returned payments will be expected to make payments via cash, money order, or cashier's checks only.

Can you waive my copay?

We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.

Do you charge for completing forms?

Completing disability forms, FMLA forms, and other requested supplemental insurance forms requires time away from patient care and day-to-day business operations. A prepayment of $25.00 per form is required. Please understand that to complete forms, your medical record must be reviewed, forms completed and signed by the physician and copied into your medical record. Some of these forms can be quite complicated and tedious to fill out. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow 5 business days for this process.

What if I missed my appointment to see the physician?

We understand that unforeseen issues can occasionally cause you to miss an appointment. Because our highly skilled physicians set aside dedicated time for you, we have a policy in place to address missed appointments and last-minute cancellations.

Office Appointment: If you need to reschedule or cancel an office appointment, please call our office at least **24 hours** in advance. For Monday appointments, cancellations must be made by noon on the preceding Friday.

Please be aware that patients who miss more than three appointments without providing a 24-hour notice may be subject to a **$50 missed appointment fee**. This fee must be paid before your next scheduled appointment.

Ancillary Tests or *Surgical Appointment:* For specialized services, such as EMG/NCV, arterial studies, or surgery, a fee of **$100.00** will be charged to any patient who fails to show up for an appointment or cancels with less than **72 hours** of notice. For appointments scheduled on a Monday, the cancellation must be made by noon on the preceding Friday.

I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by Advanced Podiatry Specialists to simplify insurance reimbursement *for* the services provided to me. I acknowledge that these policies do not obligate Advanced Podiatry Specialists to extend credit to me for services provided.

Patient or authorized representative signature: _____Date: _____

Patient or authorized representative name: _____